



Department of Veterans Affairs

## Former POW Medical History

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PLEASE TYPE OR PRINT YOUR ANSWERS IN INK. DO NOT COMPLETE SHADED AREAS. WHEN YOU NEED MORE SPACE, CONTINUE YOUR REMARKS ON A BLANK SHEET OF PAPER.

## SECTION A. IDENTIFYING DATA

1. NAME (Last, First, Middle)			1a. ADDRESS (Street, City, State, Zip Code)					
2. SOCIAL SECURITY NO.		3. VA CLAIM NUMBER						
4. AGE				5. ACTIVE MILITARY SERVICE (Check all that apply)				
A. PRESENT	B. ON CAPTURE	C. ON REPATRIATION	D. ON DISCHARGE	<input type="checkbox"/> ARMY	<input type="checkbox"/> NAVY	<input type="checkbox"/> AIR FORCE		
				<input type="checkbox"/> MARINE CORPS	<input type="checkbox"/> COAST GUARD			
				<input type="checkbox"/> OTHER (Specify)				
6. DATE OF INDUCTION INTO ACTIVE MILITARY SERVICE		7. DATE OF MILITARY DISCHARGE		8. SPECIFY TYPE OF MILITARY DISCHARGE		9. LAST MILITARY IDENTIFICATION NUMBER		
10. COMPLETE EACH BLOCK		RANK/GRADE	BRANCH OF SERVICE	11. MARITAL STATUS				
				(Check appropriate categories)				
A. AT TIME OF INDUCTION				Single Married Divorced Separated Widowed				
B. AT TIME OF CAPTURE				A. AT TIME OF INDUCTION				
C. AT TIME OF REPATRIATION				B. AT TIME OF CAPTURE				
D. AT TIME OF MILITARY DISCHARGE				C. AT TIME OF REPATRIATION				
12. NAME(S) OF COUNTRY(IES) IN WHICH YOU WERE A PRISONER				D. AT PRESENT				
13. PRISONER OF WAR CATEGORY (Check all that apply)				14. THEATER(S) IN WHICH YOU PARTICIPATED (Check all that apply)				
<input type="checkbox"/> WWI <input type="checkbox"/> WWII (Europe) <input type="checkbox"/> WWII (Pacific) <input type="checkbox"/> KOREAN				<input type="checkbox"/> CHINA, BURMA, INDIA <input type="checkbox"/> PACIFIC <input type="checkbox"/> KOREA <input type="checkbox"/> EUROPE				
<input type="checkbox"/> VIETNAM <input type="checkbox"/> OTHER (Specify)				<input type="checkbox"/> SOUTHEAST ASIA <input type="checkbox"/> OTHER (Specify)				

## SECTION B. HISTORY OF CAPTIVITY

15. APPROXIMATE DATE OF CAPTURE		16. WERE YOU CAPTURED ALONE		17A. WERE YOU CAPTURED IN A GROUP		17B. IF SO, HOW LARGE WAS THE GROUP	
		<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO			
17C. DID THE GROUP REMAIN INTACT DURING CAPTIVITY		17D. HOW MANY OF YOUR ORIGINAL GROUP SURVIVED CAPTIVITY		18. CIRCUMSTANCES OF CAPTURE (Check all that apply)			
<input type="checkbox"/> YES <input type="checkbox"/> NO				<input type="checkbox"/> IN A BATTLE <input type="checkbox"/> DURING ISOLATION OF YOUR UNIT <input type="checkbox"/> DURING ISOLATION FROM YOUR UNIT			
				<input type="checkbox"/> DURING AN ADVANCE <input type="checkbox"/> DURING A RETREAT <input type="checkbox"/> AIRCRAFT WAS SHOT DOWN			
				<input type="checkbox"/> ORDERED TO SURRENDER BY A HIGHER US OR ALLIED AUTHORITY <input type="checkbox"/> OTHER (Specify) <input type="checkbox"/> SHIP WAS CAPTURED/SUNK			
19A. WERE YOU INJURED DURING CAPTURE (If yes, described how you were injured) <input type="checkbox"/> YES <input type="checkbox"/> NO							
19B. DESCRIBE YOUR INJURY(IES) (If you do not have enough space, continue in item 62.)							
20. WHAT TYPE OF WORK DID YOU DO IN CAPTIVITY (Check all that apply)				21A. DID YOU PARTICIPATE IN A PLAN TO ESCAPE		21B. DID YOU MAKE AN ACTIVE ATTEMPT TO ESCAPE	
<input type="checkbox"/> NONE <input type="checkbox"/> FARM <input type="checkbox"/> CONSTRUCTION				<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	
<input type="checkbox"/> MINE <input type="checkbox"/> DOCK <input type="checkbox"/> FACTORY							
<input type="checkbox"/> OTHER (Specify)				21C. IF SO, WERE YOU SUCCESSFUL		22. LENGTH OF CAPTIVITY IN MONTHS	
				<input type="checkbox"/> YES <input type="checkbox"/> NO			
23. NAME(S) OF PRISON(S) (Check here if you do not know <input type="checkbox"/>				24. LOCATION(S) OF PRISON(S) (Check here if you do not know <input type="checkbox"/>			

25. EXPERIENCES DURING CAPTURE		YES	NO	NO. OF TIMES	NO. OF DAYS	26. ISOLATION IN CLOSE QUARTERS		YES	NO	NO. OF TIMES	NO. OF DAYS
A. INTIMIDATION						A. PRISON SHIPS					
B. BEATINGS						IF YOU WERE ON A PRISON SHIP, WAS IT ATTACKED					
C. WITNESSED BEATINGS						B. RAILROAD CARS					
D. PHYSICAL TORTURE						IF YOU WERE HELD IN A RAILROAD CAR, WAS IT ATTACKED					
E. WITNESSED PHYSICAL TORTURE						C. SOLITARY CONFINEMENT					
F. PSYCHOLOGICAL TORTURE (Brain Washing)						D. OTHER (Specify)					
27. WERE ATTEMPTS MADE TO USE YOU FOR PROPAGANDA PURPOSES				28. WOULD YOU BE WILLING TO DISCUSS WITH THE INTERVIEWING MEDICAL EXAMINER YOUR RELATIONSHIP WITH YOUR FELLOW POW'S				29. WOUNDS AND INJURIES DURING CAPTIVITY (Check all that apply)			
<input type="checkbox"/> YES <input type="checkbox"/> NO				<input type="checkbox"/> YES <input type="checkbox"/> NO				<input type="checkbox"/> NONE <input type="checkbox"/> HEAD <input type="checkbox"/> CHEST <input type="checkbox"/> ABDOMEN <input type="checkbox"/> BACK <input type="checkbox"/> ARMS <input type="checkbox"/> LEGS <input type="checkbox"/> OTHER (Specify)			
30. I AM UNABLE TO FUNCTION OR WORK BECAUSE OF PSYCHOLOGICAL OR EMOTIONAL STRESS								<input type="checkbox"/> YES <input type="checkbox"/> NO (If yes, please explain)			
31A. DID YOU EXPERIENCE		YES	NO	31B. DID YOU EXPERIENCE		YES	NO	NO. OF TIMES	NO. OF DAYS		
A. PROLONGED PERIODS OF FEAR AND ANXIETY				A. FORCED MARCHES							
B. PROLONGED PERIODS OF DEPRESSION				WERE YOUR FORCED MARCHES ATTACKED							
C. PROLONGED PERIODS OF FEELINGS OF HELPLESSNESS				B. THOUGHTS OF SUICIDE							
D. LONELINESS AND ISOLATION FROM OTHER POW'S				C. ATTEMPTS AT SUICIDE							
E. PERIODS OF NIGHTMARES, CONFUSION, OR DELIRIUM DURING CAPTIVITY				D. OTHER (Specify)							
32. EXPOSURE TO COLD (Check those you experienced)	BEFORE CAPTURE	IN CAPTIVITY	33. EXPOSURE TO HEAT (Check those you experienced.)	BEFORE CAPTURE	IN CAPTIVITY	34. RADIATION EXPOSURE (Explain specifically)					
A. NONE			A. NONE								
B. FROSTBITE			B. HEAT EXHAUSTION								
C. TRENCHFOOT			C. LOSS OF CONSCIOUSNESS								
D. IMMERSION FOOT OR HAND			INDICATE NO. OF TIMES PER DAY								
E. IMMERSION IN COLD WATER			D. OTHER (Specify)			35. COMMUNICATIONS					
F. OTHER (Specify)						CHECK ONE A. DID YOU RECEIVE NEWS FROM HOME <input type="checkbox"/> YES <input type="checkbox"/> NO B. HOW OFTEN <input type="checkbox"/> OCCASIONALLY <input type="checkbox"/> RARELY C. WAS THIS SIGNIFICANT <input type="checkbox"/> YES <input type="checkbox"/> NO					
						36. DIETARY HISTORY Estimate weight in pounds					
						ON ENTERING SERVICE		LOWEST WEIGHT IN CAPTIVITY		PRESENT	
37. IF YOU WISH, BRIEFLY DESCRIBE ONE OF YOUR WORST EXPERIENCES AS A CAPTIVE											

38. ADEQUACY OF DIET DURING CAPTIVITY (Check appropriate box for each category)												
AVERAGE DAILY DIET			NONE	INADE- QUATE	ADEQUATE	AVERAGE DAILY DIET			NONE	INADE- QUATE	ADEQUATE	
A. WATER						H. DAIRY PRODUCTS						
B. BROTH						I. MEAT						
C. SOUP WITH PIECES OF FISH, MEAT, OR POULTRY						J. NUTS						
D. BREAD						K. FISH						
E. LEGUMES (Peas/Beans)						L. FRUITS						
F. RICE						M. VEGETABLES						
G. POTATOES						N. MILLET (Small seeded cereals and grasses)						
OTHER (Specify)												
39. SPECIFIC DISEASES ACQUIRED DURING CAPTIVITY (Check appropriate box for each category)												
DISEASE		YES	NO	DISEASE		YES	NO	DISEASE		YES	NO	
DYSENTERY				TUBERCULOSIS				SKIN DISEASE				
MALARIA				WORMS				VITAMIN DEFICIENCY				
PNEUMONIA				SCABIES				PELLAGRA				
								OTHER (Specify)				
40. DID YOU EXPERIENCE ANY OF THE FOLLOWING DURING CAPTIVITY (Check appropriate box for each category)												
	YES	NO		YES	NO		YES	NO		YES	NO	
CHEST PAINS			CAVITIES			SUNBURN			FEVER			
RAPID HEART BEATS			TOOTH ABSCESS			SKIN ULCERS			FREQUENT URINATION			
SKIPPED OR MISSED HEART BEATS			LOSS OF TEETH			BOILS			BLOODY URINE			
IMPAIRED VISION			SORES AT THE ANGLES OF THE MOUTH			PALE SKIN			KIDNEY STONE			
POOR NIGHT VISION			SORE TONGUE			BREAST LUMPS			UNSTEADY GAIT			
PARTIAL BLINDNESS			EXCESSIVE THIRST			NAUSEA			SWELLING IN THE JOINTS			
EYE ULCERS			SWOLLEN GLANDS			VOMITING			SWELLING OF THE LEGS AND/OR FEET			
HEARING DISORDER			SKIN RASHES			DIARRHEA			SWELLING OF THE MUSCLES			
BLEEDING GUMS			BLISTERS			EPISODE(S) OF JAUNDICE			BROKEN BONES			
TOOTHACHE			DRY SCALY SKIN			CHILLS			BURNS			
NUMBNESS, TINGLING, OR PAIN IN THE FINGERS OR FEET (Electric/Burning Foot)			NUMBNESS OR WEAKNESS IN THE ARMS OR LEGS			ACHES OR PAINS IN THE MUSCLES AND/OR JOINTS			PSYCHOLOGICAL OR EMOTIONAL PROBLEMS			
41. AVAILABILITY OF MEDICAL TREATMENT DURING CAPTIVITY			YES	NO	(IF YES, QUALITY)			42. OPERATIONS PERFORMED DURING YOUR PERIOD OF CAPTIVITY <input type="checkbox"/> NONE  <input type="checkbox"/> AMPUTATIONS ONLY (Specify)  <input type="checkbox"/> OTHER (Specify)				
					GOOD	FAIR	POOR					
A. MEDICAL TREATMENT WAS ADEQUATE												
B. SURGICAL TREATMENT WAS ADEQUATE												
C. DENTAL TREATMENT WAS ADEQUATE												

### SECTION C. HISTORY OF RELEASE FROM CAPTIVITY AND REPATRIATION

43. APPROXIMATE DATE YOUR CAPTORS LOST CONTROL	44. APPROXIMATE DATE YOU WERE RETURNED TO FRIENDLY CONTROL	45. BRIEFLY DESCRIBE THE CONDITIONS OF YOUR RELEASE AND RESCUE	
46. IN YOUR OPINION, HOW THOROUGH WERE THE REPATRIATION EXAMINATIONS <i>(Including medical and psychological debriefing and counseling)</i>		47. DID US AUTHORITIES BRIEF YOU ON EVENTS WHICH OCCURRED WHILE YOU WERE IN CAPTIVITY	48. WERE YOU SATISFIED WITH THE WAY YOU WERE TREATED ON REPATRIATION
<input type="checkbox"/> GOOD <input type="checkbox"/> FAIR <input type="checkbox"/> INADEQUATE <input type="checkbox"/> NONE		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
49A. DID THE VA GIVE YOU A DISABILITY RATING AFTER REPATRIATION	49B. IF YES, WHAT WAS THE PERCENTAGE	49C. WHAT WAS THE DISABILITY	
<input type="checkbox"/> YES <input type="checkbox"/> NO			
50A. DID YOU EVER APPLY TO THE VA FOR DENTAL CARE BENEFITS BASED ON YOUR FORMER POW STATUS	50B. IF YES, DID YOU RECEIVE A DENTAL RATING	50C. WHAT WAS THE RATING	
<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO		
51. DO YOU FEEL THAT YOU WERE PROMOTED TO THE RANK YOU WOULD HAVE BEEN/ SHOULD HAVE BEEN IF YOU HAD NOT BEEN CAPTURED		52. DID YOU RECEIVE THE MEDALS YOU BELIEVE YOU DESERVED	
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	

### SECTION D. ADJUSTMENT TO POST WAR LIFE

53A. DID YOU CONTINUE MILITARY SERVICE AFTER REPATRIATION	53B. IF YES, HOW MANY ADDITIONAL YEARS DID YOU SERVE	54A. DID YOU PERFORM RESERVE DUTY	54B. IF YES, HOW MANY YEARS DID YOU SERVE
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	
55A. DID YOU ATTEND SCHOOL AFTER RELEASE FROM ACTIVE DUTY	55B. WHAT WAS YOUR HIGHEST EDUCATIONAL ATTAINMENT	55C. NUMBER OF YEARS YOU ATTENDED SCHOOL	56A. HOW SOON AFTER DISCHARGE DID YOU ENTER CIVILIAN EMPLOYMENT
<input type="checkbox"/> YES <input type="checkbox"/> NO			
56B. WAS THIS THE FIRST CIVILIAN SECTOR JOB YOU EVER HAD	57A. DID YOU RETURN TO THE SAME JOB YOU HELD BEFORE ENTERING THE MILITARY	57B. HOW MANY YEARS HAVE YOU WORKED SINCE DISCHARGE FROM THE MILITARY	58A. HOW MANY DIFFERENT JOBS HAVE YOU HELD SINCE REPATRIATION
<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO		
58B. WHAT WAS THE LONGEST PERIOD OF CONTINUOUS EMPLOYMENT SINCE REPATRIATION	59. DID YOU FIND IT DIFFICULT TO ADJUST TO CIVILIAN LIFE	60A. HOW WOULD YOU DESCRIBE YOUR PRESENT STATE OF HEALTH	
	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> EXCELLENT <input type="checkbox"/> GOOD <input type="checkbox"/> FAIR <input type="checkbox"/> POOR	
60B. BRIEFLY DESCRIBE YOUR PRESENT STATE OF HEALTH		61. DESPITE THE MANY NEGATIVE ASPECTS OF YOUR POW STATUS, WERE THERE ANY POSITIVE ASPECTS TO YOUR EXPERIENCE <i>(If Yes, Please Specify)</i>	
		<input type="checkbox"/> YES <input type="checkbox"/> NO	

63. SIGNATURE	64. DATE
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